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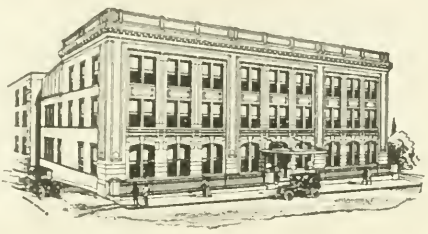

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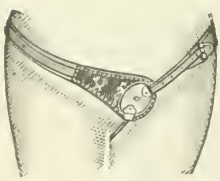

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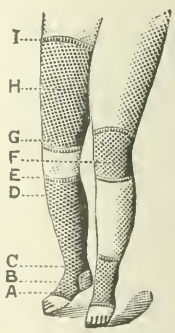

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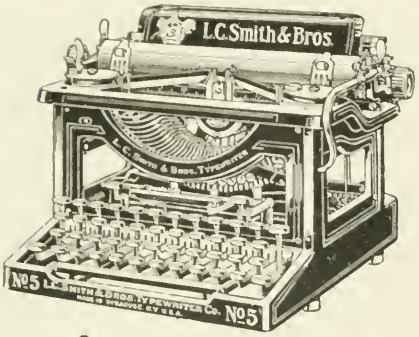

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MARYLAND
MEDICAL JOURNAL

A Journal of Medicine and Surgery

Vol. LVII, No. 10 BALTIMORE, OCTOBER, 1914 Whole No. 1157

PRESIDENTIAL ADDRESS.

REMARKS ON THE PRINCIPLES OF MEDICAL ETHICS.

By Randolph Winslow, M.D., LL.D.,

President of the Medical and Chirurgical Faculty of Maryland.

To aspire to the presidency of such an ancient and distinguished association as the Medical and Chirurgical Faculty of Maryland is a laudable ambition; to expect the realization of this ambition is an audacious conceit. I acknowledge that I have entertained this ambition, but have not had the assurance to expect its attainment. Placed, therefore, by your favor in this chair, which has been filled by so many learned and distinguished men, I beg to extend my profound thanks for this high honor that you have conferred upon me.

The Medical and Chirurgical Faculty of Maryland was founded in 1799 for the purpose of "promoting and disseminating medical and chirurgical knowledge throughout the State," and of "alleviating the calamities and miseries of their fellow-citizens." One hundred and one of the most prominent physicians of the State were the incorporators of this important and far-reaching enterprise. While some of the medical practitioners at that time were men of high culture and of excellent qualifications, others were ignorant quacks, without training or skill, who preyed upon a helpless public. It was for the purpose of combating this evil that this Faculty was founded. It was made the authority by which the right to practise was acquired, and for 39 years it exercised this right through its two boards of examiners, one for the Western and one for the Eastern Shore. In 1838 the Legislature annulled this provision, illegally, and for 54 years this Faculty exercised only a moral supervision over the practitioners of the State. In 1892, however, by an act of the Assembly, the licensure to practise was again vested in this Faculty through a special board of medical examiners.

It rests, therefore, with this body to determine who shall practise medicine in this State, though, unfortunately, it does not possess the power to cancel the license of those who may prove un-

worthy of the trust that has been placed in their hands. While this Faculty cannot deprive anyone of the right to practise after he has been licensed by the examining board, it has the right through its component societies to determine the conditions on which persons may be received into membership, and may continue to hold membership, in both this Faculty and in the American Medical Association. For over a century the Medical and Chirurgical Faculty of Maryland has been a most important factor in promoting and dissemmating medical and chirurgical knowledge throughout the State, and in calling into being numerous agencies for alleviating the calamities and miseries of its fellow-citizens. It has, in addition, endeavored to protect the citizens of the State from ignorant and rapacious practitioners, as well as from charlatans who are dishonest even if not ignorant. It has also striven to inculcate high principles of ethical conduct between the members of the profession in their relations with one another and with the public. There was perhaps no State in the Union in which there was a more punctilious professional etiquette than in Maryland; and we look with admiration akin to veneration upon those worthies of an earlier day, with their dignity, urbanity and stately courtesy—qualities that are so frequently lacking at the present time.

In a primitive condition of civilization the elemental forces prevail, but as society becomes more complex it becomes necessary to have rules and laws to govern the conduct of its members, to restrain the vicious and to protect the weak and helpless. In similar manner it has been found necessary to prescribe certain principles of conduct, formerly called the "code of ethics," to regulate the relations of physicians to each other and to the public. These principles of medical ethics have been formulated by the American Medical Association, of which we are an integral part, and are consequently binding upon us; though it seems to be impossible for the laity, and especially for the public press, to understand why every physician should not do as he pleases, notwithstanding that every other branch of organized society has its own rules and regulations to which its members are required to subscribe. The underlying principle of the code of ethics is the command of Christ, "Do unto others as you would have them do unto you," which we also find expressed in a personal manner by Confucius: "What I do not wish to have done unto me, I likewise wish not to do unto others." If everyone lived up to these principles of conduct there would be but little necessity for the formulation of any code of ethics, but, unfortunately, human nature is weak, and it is necessary that physicians associated together should understand clearly certain broad rules of conduct by means of which the dignity, honor and usefulness of the profession is maintained. Medicine is not a trade, it is a profession; and one that is advanced well-nigh to a science. The methods of the tradesman, hawking his wares, are not reputable for the honorable practitioner of medicine, and are forbidden. One of the greatest efforts of this Fac-

ulty has been to maintain a high degree of professional honor and to prohibit the commercialization of the profession. Through its board of medical examiners the public is measurably protected from incompetent practitioners, though much is still to be desired in this direction. Every year, however, progress is being made in the preparation of medical students, and a great advance in both scientific and practical medicine (if, indeed, the terms are not synonymous) is constantly going on. What shall we say in regard to the moral tone of the profession? Has it also advanced to a higher plane? We must answer with shamefacedness, No! The opening statement in the Principles of Medical Ethics of the A. M. A. is: "A profession has for its prime object the service it can render humanity; reward or financial gain should be a subordinate consideration. In choosing this profession an individual assumes an obligation to conduct himself in accord with its ideals." As has been stated, we are bound to abide by and uphold the principles of ethics adopted and promulgated by the A. M. A. I therefore beg to call attention to some subjects upon which especial emphasis is laid in the declaration of the principles of ethics of that body. One of the cardinal principles of ethics of an earlier day was that it was improper for the physician to reveal the nature of a patient's ailment, especially if it was of such a characater as to bring shame or embarrassment to the sufferer or to his family. Now it is of frequent occurrence to see in the daily papers that Mr. or Mrs. Blank is being treated for cancer or for some other serious condition. To thus advertise broadcast the infirmities of our patients is both indelicate and improper, and should not be tolerated. Again, we frequently see in the daily papers that prominent citizens living at a distance are coming to Baltimore for treatment. How can such matters get into the papers? I hardly suppose the patients announce their plans or their ailments to the reporters, yet full particulars are conspicuously heralded to the public. This notice is also highly improper and unprofessional, and should not be allowed. It is a covert advertisement which is both in bad taste and reprehensible, and is specifically condemned in the code of ethics, which says: "It is unprofessional to procure patients by indirection through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-laudations defy the traditions and lower the tone of any profession, and so are intolerable." Notwithstanding this sweeping condemnation, the names of members of this Faculty and of the American Medical Association appear *ad nauseam* in the daily papers in relation to wonderful cures that are expected to be wrought, and which usually are not wrought. It is impossible that the names of physicians should not be mentioned occasionally in connection with important or unusual cases, or where distinguished or prominent patients are concerned, but this should occur but seldom, and such public notice should be issued by the family, and not by the doctor. Not only

does the A. M. A. prohibit this direct or indirect advertising, but the newly-organized American College of Surgeons, of which some of us are fellows, requires as a prerequisite to fellowship the signing of a solemn pledge, one paragraph of which reads as follows: "Moreover, I pledge myself, so far as I am able, to avoid the sins of selfishness, to shun unwarranted publicity, dishonest money-seeking and commercialism as disgraceful to our profession." Can anything be stronger than this reprobation by both the A. M. A. and the College of Surgeons? How can one who is guilty of such practices become or remain a fellow of either body? It is also reprehensible to publish or to permit to be published accounts of wonderful operations, which, according to the reporter, are amongst the rarest and most delicate in surgery, such as resection of a portion of a rib for the evacuation of pus from the thorax or the grafting of skin upon a raw surface. Equally to be condemned is the ascription of remarkable therapeutic or diagnostic discoveries to certain individuals, when the actual discovery was made, probably, before such persons were born. When by chance such statements issue from the fertile brain of a reporter and find their way into the public press, they should be promptly disclaimed. The papers are filled with such notices, and they usually pass unchallenged. It is undoubtedly true that the public is entitled to be informed of those matters in which they are vitaliy interested, even when it upsets their previous ideas and prejudices. Thus, even in a matter as thoroughly demonstrated as the efficiency of vaccination against smallpox, there is still either the greatest carelessness or the densest and most culpable ignorance; and it is necessary that the public should be warned from time to time of the disastrous results of the neglect of this simple and almost harmless expedient. They should also be informed of the means by which typhoid fever is spread and the prophylactic measures for its prevention. The relation of flies, mosquitoes and other insects to the propagation of certain infections and zymotic diseases is also a matter of public interest; and the eradication of these pests is of the greatest public utility. All these and many other matters of public health may well be discussed, and even forced upon the attention of the people. The curability of tuberculosis, when taken in its incipiency and treated judiciously, is also something that should be known to everyone. This Faculty has for years waged a campaign of public instruction in regard to these matters, and has not only taught the public concerning their dangers, but has succeeded in having the State erect sanitaria and hospitals for the treatment of cases of tuberculosis, insanity and other widespread ailments. At the present time a crusade against cancer is being waged all over the country. It is a most important subject and of vital interest to all the people. It is an absolutely proper subject for discussion in public meetings, but great care is necessary to make the discussion impersonal, and not a means of personal advertisement. In my opinion, it would be best to leave the crusade against cancer in the hands of physicians rather than

of surgeons; but if it is conducted by surgeons, personal statistics of cures should not be given, nor does it appear to me to be ethical to give magic-lantern demonstrations of pathological conditions to a mixed audience. It savors too strongly of personal exploitation.

Fellows of the American College of Surgeons are required to pledge themselves to make their fee commensurate with the services rendered and with the patient's rights, and to avoid discrediting their associates by taking unwarranted compensation. I think it is but seldom that a physician or surgeon receives greater compensation than he is entitled to. How often, alas, does he receive less than he is entitled to, or nothing at all! Still there is danger that charges disproportionate to the services may be made, or that the services may be exaggerated in order to justify a larger fee. In making charges for professional services, one should carefully consider the ability of the patient to pay, as well as the injurious effect of unusual and exhorbitant fees upon the family physician or other medical associate in the case. Fee splitting or the giving of commissions to agents or solicitors has never been largely practised in our State, and I only desire to call attention to the fact that it is absolutely prohibited by both the A. M. A. and the College of Surgeons.

In the relations of physicians with each other many points of difference are bound to arise; hence the necessity for some general rules to govern the action of practitioners in such circumstances. It is considered unethical for one physician to visit the patient of another professionally in his absence and without his knowledge, except in an emergency. If the family or patient desires to make a change in their medical attendant, the first physician should be formally dismissed before the second one assumes charge of the case. This rule has been frequently disregarded in recent years, and its breach has been the cause of many bitter complaints and animosities between members of the profession. Let us be more careful in the future to observe this precept. A consultant should meet his appointment promptly, but if for any reason either the attending physician or the consultant is delayed, the latter should not examine the patient of the former unless in the presence of an emergency, or unless it will not be convenient to make another visit. In such cases an examination may be made, but the result of the examination should not be made known to the patient, but should be communicated in writing to the attending physician. A consultant should not take charge of the patient of the physician with whom he is in consultation during the same illness, unless with the consent of the attending physician. Indeed, it will be better for the consultant to avoid all appearance of evil by refusing to attend the same case in subsequent sicknesses, unless the patient has in the meantime employed some other physician than the one first mentioned. When patients are referred to specialists to be treated for ailments requiring special knowledge and skill, they should be returned to their regular at-

tendant when the special services are finished. Much complaint has been made in regard to the failure of certain specialists to observe this rule. Also when cases are referred to specialists for an opinion, they should be returned to the physician referring them, and not directed to some other person. We know of numerous cases that have been referred to eminent authorities for opinions, who have either been kept by the eminent persons themselves or have been referred to other physicians or specialists, and have not been returned to the original attendants. This is manifestly improper, and is the cause of much complaint and bitter feeling.

A physician who has been called to see the patient of another practitioner in an emergency, or during the absence of the regular attendant, should not assume charge of the case, but should relinquish it upon the arrival of the family physician. If for any reason he does succeed another in attendance on a case, he should be especially careful not to make unfavorable criticism of the former attendant, or by indirect insinuation or inuendoes to cast reflections on his predecessor. Such criticisms or reflections are often eagerly seized upon by evil disposed persons, or by persons who have not secured the benefits that were expected from treatment, to bring lawsuits against their former attendants. It is reprehensible for physicians to encourage litigation against their fellows, and it may be safely said that very few lawsuits would be instituted and still fewer prosecuted if the family physician discouraged the suit and refused to testify in favor of the patient, except under compulsion. While there may be exceptions to most rules, it is my personal opinion that physicians should decline to testify against their fellow-practitioners as experts, or in any other manner, except as compelled to do so by law. Unfortunately, lawsuits against medical men are of frequent occurrence, causing them much anxiety and distress, and putting them to financial stress and loss. These suits are encouraged, if not instigated, by the family doctor in many cases, and are supported by the testimony of physicians who are as ignorant as they are venal. It should be considered a breach of professional ethics for a physician to aid in bringing a suit against a colleague, or to testify against his fellow except under legal compulsion.

I have touched briefly on a few points of professional conduct that appear to me to demand criticism and reprehension at the present time. I should willingly have yielded this task to others, but, temporarily, I seem to be set as a watchman, whose duty it is to sound the alarm upon the approach of danger; and faithful to that duty, I now declare that we are confronted with the danger of the commercialization of the medical profession, and I enter my solemn protest against this iniquity. This is a commercial age, and there is the tendency on the part of some to judge professional success largely by the ability of a medical man to blow his own trumpet and to secure the attention of the public and the press by commercial methods. It is against this commercialism that the medical profession of Maryland hitherto has stood, and

still stands, as a stone wall; but a minority have emulated the example of the tradesman, and even of the quack, and have brought discredit upon a noble and altruistic calling.

Who are these ethical malefactors who break with impunity every rule of the professional decalogue? Are they insignificant and obscure members of the profession who are compelled to adopt these devices in order to secure means of subsistence? On the contrary, they are, generally, men of commanding ability and of great attainments, occupying high positions in the professional world, into whose laps Dame Fortune has poured her choicest gifts. They are not ignorant of the rules of medical ethics, but they have wilfully disregarded them. They have set a most iniquitous example to the younger and less prominent members of the profession, who perforce must follow in their footsteps. It is useless to attempt to maintain a high standard of ethics and to require the small man to observe this standard while he sees the big man disregard it. The more eminent the violator of the principles of ethics the more culpable is he, and the greater the damage that is done. We cannot hold a double standard; we must be consistent. We must have no respect of persons, but must maintain a high standard for small and great alike, or let down the bars for all. But are we willing to lower the standard of ethics in this State, and to sell the noble heritage that has come down to us from our ancestors? God forbid! Let us the rather return to the faith of our fathers and resolve that, let others do as they may, the medical profession of Maryland will cling to the best traditions of the past, as well as look forward with hope and altruism to the golden future.

The Clinics of John B. Murphy, M.D., at Mercy Hospital, Chicago. February, 1914. Published Bi-Monthly by W. B. Saunders Company, Philadelphia and London. Baltimore: The Medical Standard Book Co. Per year, $8. Vol. III, No. I.

As its predecessors, the February number of Murphy's Clinics expostulates for the larger part upon bone surgery. It is to this line of surgery that Dr. Murphy is at present devoting a large part of his energy. As a matter of fact, it is he who has placed bone surgery upon its present basis. Therefore, any matter concerning the same directly from the pen of Dr. Murphy cannot help but be welcomed by the surgical fraternity of the United States. From the foregoing we do not wish to convey the impression that this number contains nothing else save bone surgery, for such is not the case. As a matter of fact, there are articles on such divergent topics as Lord Lister and Antiseptic Surgery, Nitrous Oxide Anesthesia, Gastric Ulcer and Carcinoma, Metastatic Infections, Removal of Enlarged and Dilated Stump of Gall-Bladder, Radical Operation for Carcinoma of the Breast, with Description of Dr. Murphy's Special Technic, etc. This number should prove as welcome to the profession as any of its predecessors. No progressive surgeon can be without its bi-monthly appearance.

THE CURABILITY OF CANCER.*

By Joseph H. Branham, M.D.

This is the most important surgical question facing the profession at the present time; all other diseases have yielded, at least partly, to the great improvements and discoveries of modern medicine and surgery. Cancer, however, has gone on steadily increasing in all parts of the civilized world, until the most reliable statistics indicate that it is twice as prevalent now as it was fifty years ago. In the meantime, thousands of investigators everywhere have been striving to unravel the cause and discover some means to prevent this scourge, so far without result. The agents we have for combating malignant diseases all arrive at the desired result by destroying the involved tissue and eliminating the malignant cells from the surrounding parts.

That cancer, primarily, is a local disease is the opinion of all scientific men of the present time; therefore, if the neoplasm can be entirely eradicated before its dissemination throughout the deeper parts of the body, a permanent cure will be effected.

That this disease is frequently developed from chronic lesions of the skin and mucous membrane is undoubtedly true. These consist of hyperphasia and chronic irritation associated with loss or impairment of the epithelial covering. Among the most common are warts or moles on the skin, fissures, lacerations and ulcers on the mucous membranes. The careful eradication of these lesions has done much toward the prevention of cancer. Cancer of the stomach usually develops from a chronic lesion of this kind, especially ulceration. This form of cancer seems to be increasing very rapidly, according to Mayo. It is much more frequent in men than in women, and many suggestions have been made explaining these facts. It would seem to me that the excessive use of alcohol, especially in the concentrated and highly irritant forms, is probably one of the etiological factors.

At the present time the only means that we possess for increasing the number of cures in this disease is early and complete operation. Other methods, such as radium and the X-ray, may be used after operation, or in inoperable cases with some possible hope of ameliorating the symptoms, but no one, I believe, would suggest substituting these methods for extirpation in the ordinary cases of malignant growth. An early interference is to be promoted in two ways—the most important of these is the development in our profession of an enthusiastic and positive sentiment toward this end. The laity always follows the profession in these matters, and, in my opinion, we must depend on ourselves to disseminate the proper knowledge to these patients, impressing the terrible danger of procrastination when symptoms of malignant diseases appear. It is the hopeless attitude that has been taken

*Read at the annual meeting of the Medical and Chirurgical Faculty of Maryland, April 29, 1914.

by physicians in the past, and, to a less degree, at the present time, that has caused so much delay among patients in seeking surgical relief.

I am inclined to believe, in spite of the unfavorable comments from Germany, that proper publicity in the general press is of some advantage, and that it can be made still more useful by proper co-ordination between the papers, the magazines and the profession. Meetings like the one held in this hall a few weeks ago will do much good. This method, while accomplishing favorable results, is capable of doing much harm. Neurasthenics, reading the descriptions of malignant diseases, immediately develop all the symptoms of cancer and go to the surgeon for operation; probably, in many instances, not taking the opinion of one surgeon, but go to another seeking some one to remove an imaginary cancerous growth. The tendency of the press to publish exaggerated statements as to new and unproved methods of treatment has, undoubtedly, prevented many patients from having an early radical operation done. By giving a supplementary report of some cases of long standing, I hope to add something toward promoting a more hopeful view of this disease:

Mr. J. R., aged 20, operated on October 12, 1899, for malignant tumor of the pylorous associated with aberrant pancreas. I heard from this man about a year ago, when he was still in excellent health. The sections in this case were reviewed by Dr. William H. Welch.

Mrs. D. was in my office last week looking the picture of health. In October, 1897, I did a hystorectomy on her for cancer of the body of the uterus.

Mrs. W., aged 57, operated February 26, 1895, for cancer of the rectum and vagina. In this case the lower three and one-half inches of the rectum, together with the perineum and posterior wall of the vagina, were removed. A number of the post-peritoneal glands were also excised. She died about one year ago of old age with no recurrences.

Miss J., operated January, 1892, for cancer of the right breast. During the past month she has gone through an attack of pneumonia and is now in good health.

Mr. G., operated November, 1907, for a large cancer of the stomach engrafted on an old ulcer. This patient is a prominent business man of our city. He has suffered from nervous indigestion at times, but is energetic and successful. I have recently examined him and found him entirely free from any indication of recurrence.

These are a few cases from my operations. I give them because of their long standing and permanent cures. All the specimens were examined by competent pathologists and the diagnosis in each case is positive. My results have been about the average. Most cases come too late; others show intense malignancy and die from quick recurrence, and many have been lost sight of.

One thing we must recognize is that, if our results are to improve greatly in internal cancer, the operations must be exploratory in character.

The diagnosis in the first case of cancer of the stomach reported was made by Dr. C. Urban Smith, and was positive. This was possible because the growth was annular and was just at the pylorus. If we wait for a positive diagnosis in most gastric cases, operation is useless. On the other hand, many cases may be saved if the exploration is made in the early stages.

Dr. William J. Mayo has reported numbers of cases of cancer of the gall bladder removed during cholecystectomy for other causes with permanent success, but no successful case operated after diagnosis was made.

Careful removal of all growth with a wide margin of healthy tissue, together with the neighboring lymphatic vessel and glands, is essential. Rough handling, such as curettement of a cancerous uterus or the removal of a section for microscopic examination, often causes rapid dissemination and should always be followed by immediate operation. Grafting on the incision or on other parts of a serous membrane must be carefully avoided.

The rapid improvement in the operative treatment of cancer is gratifying. I think it is undoubted that about half of these cases are being permanently cured at this time. My experience indicates that a much larger percentage will get well if we can secure our cases early. The ones that come back are those whose operation has been delayed until too late. Each of us must impress the vital importance of early diagnosis and treatment on all our patients.

In conclusion, I wish to emphasize the necessity of removing pre-cancerous conditions; of complete and early operations; of exploration of the body cavities for diagnostic purposes in the early stages of cancer symptoms, and of extirpation of all deep-seated growths when suspicious.

LOCAL ANESTHESIA. By Dr. Arthur Shlesinger (Berlin). Translated by F. S. Arnold, B.A., M.B., B.Ch. (Oxon). Illustrated. New York: Rebman Company. Cloth, $1.50 net. 1914.

Local anesthesia is bound to come more and more into favor, therefore any work from the pen of an authority speeds the day. The subject-matter embodies a historical survey, physical principles, local anesthetics, cocaine and its substitutes, adjuvants in local anesthesia, methods of local anesthesia and their application, general technic, etc. As an aid to a better understanding of the modus operandi and sphere of usefulness of local anesthesia this little book should be found very useful. It thoroughly goes into what you can and cannot expect of local anesthesia. It is well illustrated and practical.

THE VALUE AND LIMITATIONS OF FLUOROSCOPIC EXAMINATIONS OF THE GASTRO-INTESTINAL TRACT.

By Thomas R. Brown, M.D.

In discussing the value and the limitations of fluoroscopic examinations of the digestive tract, based on upwards of 1500 cases, it would seem wiser, first, to call attention to the methods employed; second, to enumerate briefly the conditions in which this method of diagnosis is of especial value, and third, to mention the conclusions which we seem justified in drawing.

Our methods are as follows: The patient is given one ounce of subcarbonate of bismuth 18 hours before the examination, urged to avoid a bowel movement if possible, and then given another ounce thoroughly stirred up in a glass of water either just before or synchronous with the examination. In the latter case we believe that a fairly thick gruel of farina or oatmeal is preferable to water, and also an emulsion made up of mucilage of acacia, but for practical purposes the water-bismuth mixture has proven very satisfactory, and it is obviously much more convenient.

The patient is examined in the upright position, as a rule, while if there is any question as to adhesions, atony, ptosis, or dilatation, which cannot be determined in this position, he is also examined in the prone position, or even with the hips somewhat elevated, the comparison of the images obtained being of the greatest value in the diagnosis of difficult cases, especially those of suspected adhesions, of functional hour-glass stomach, and of suspected ulcer.

The stomach and intestine are examined at rest, and during deep inspirations and expirations, and the effect of deep massage given by the operator is carefully noted.

In all esophageal cases the swallowing of the bismuth is carefully noted, the patient's position being a slight rotation forward of the right side, as by this means the esophagus can be more easily made out, while in suspected esophageal obstruction it is wise to try thick as well as thin bismuth emulsions as well as thick bismuth gruel in the hope of determining something as to the nature and degree of the obstruction. Obviously in all such cases careful fluoroscopic examination of the thorax should be made to determine the presence or absence of aneurysm, neoplasm, mediastinal adenitis, etc.

In all cases where the lower bowel seems to be specially involved, such as high grades of kinking and other obstructive phenomena, congenital or acquired dilatation of the colon, etc., we have studied the patient during the administration of a bismuth emulsion enema of one or two quarts, and certainly no other method is so valuable in diagnosing disturbances in this portion of the digestive tract. A normal resistance to the inflow is noted at the various flexures, but if there or elsewhere great increase of

pressure (determined by raising the vessel containing the bismuth emulsion) is necessary before the emulsion flows past that point, it speaks for some form of obstruction—usually pathological.

We have made it a point in all cases of importance or in doubtful cases to repeat the examination at least once, as one should recognize that various outside influences, notably emotional disturbances and the condition of the psyche, can markedly modify the picture presented, especially affecting the motor functions of the digestive tract.

In cases of motor disturbance it is also well to study the patient at varying intervals after the first examination to see how rapidly the stomach empties itself; for practical purposes examination six hours later is all that is necessary, for, according to Schlesinger, the hypertonic stomach empties itself in from two to three hours, the orthotonic in from three to five, the hypotonic in from four to six, and thus the finding of some bismuth in the stomach six hours or more after its administration speaks for atony, dilatation, or pyloric obstruction—although, of course, here again the examination must be repeated to eliminate the possible influence of psychic disturbances.

We must remember that the classical views of the anatomists are wrong as to the normal position of the stomach, this viscus, especially with the patient in the upright position, being much lower than that described in the textbooks of anatomy, often reaching the iliac crests. In the prone position the stomach and large intestine often rise from two to six inches, and the absence of this ascension is suggestive of adhesions. The studies of Hertz and others have definitely shown how frequently low stomachs are to be met with in perfectly healthy students with no digestive signs or symptoms whatsoever.

As to the relative value of the fluoroscope and the X-ray photograph in the diagnosis of digestive diseases, we feel that each has its advantages. The former is much cheaper and much less time-consuming, and is thus peculiarly suitable for the polyclinic. By it we can study the motor function especially well, we can see the effect of the respiratory movements, of abdominal massage, and of change of posture. By using the diaphragm we may study with great care and over considerable time local abnormalities, defects in filling, vacant areas, dislocated and distorted portions of stomach and duodenum, etc., while it is indispensable in studying esophageal lesions, and in studying obstructive signs in the lower bowel during the administration of the bismuth enema. On the other hand, the radiograph is practically invaluable in extremely fat patients; it unquestionably can give us the finer details of the picture more distinctly, it is safer, and it furnishes a permanent record of the condition met with.

In our opinion, a combination of the two methods furnishes the best results, each acting as a check upon the other, and together increasing very materially the percentage of correct diagnoses in a field in which from these methods alone diagnosis is so difficult

because interpretation is of so much more importance than the mere image presented. Were it not for the great expenditure of time and money involved by it, Cole's method of serial radiography would be the ideal procedure, and in cases of great importance or great difficulty it should certainly be employed whenever possible.

In the case of the *esophagus* we should not forget that organic obstruction may be simulated by spasm, neurotic, hysterical or reflex in origin, the last notably in cases of duodenal ulcer with obstruction, or in cases of very marked gastroptosis—a correct diagnosis only being possible after repeated examinations, studying the level of the spasm to see if it varies, determining the effect of atropine upon it, and in certain cases even making an esophagoscopic examination. While inspection and palpation may render possible the diagnosis of the pulsion-diverticulum of the neck, we must depend on the X-ray in determining the traction-diverticulum of the lower levels of the esophagus.

In the case of the stomach we must remember that with a wide costal angle the situation of the viscus is normally much higher than with a narrow costal angle; that normally different shapes may be met with—the cowhorn, the fishhook, the textbook, and possibly the water trap; that we must wait a few moments before studying the motor function, as the introduction of bismuth inhibits for a moment the motility, although, according to Best and others, the movements of the stomach are slowed during the entire cycle by this salt; practically, however, this cannot have a very great effect.

In the diagnosis of gastric carcinoma a persistent defect in the shadow should arouse suspicion, and yet this may be absolutely simulated by adhesions, by a spastic hour-glass stomach, or by high grades of ptosis with atony. In this connection it may be well to call attention to the fact that we are not studying the gastric mucosa itself, but the bismuth contents of the stomach, the distribution of which may be most irregular.

In connection with various forms of spastic contraction of the stomach, especially the hour-glass stomach, with its larger upper and smaller lower portion, as a rule, one must not forget that while sometimes the level of the contraction corresponds to an ulcer, an erosion or a scar, nevertheless more often the hour-glass contraction is either reflex in origin, originating in duodenal ulcer, chronic appendicitis, or disease of the gall-bladder, or is the expression of a general disturbance of innervation, such as various neuroses, Graves' disease, etc. Why in this group of cases the spasm should almost always assume the same level is difficult to understand. Perhaps most careful microscopical studies might show some lesion of circular muscle, or of ganglia, or nerves at the level involved. In these spastic cases one should always try the effect of hypodermics of atropine to determine the nature of the contraction. It is well also to remember that certain of these cases may be overlooked because the spasm is so marked that a consid-

erable time elapses before any bismuth reaches the lower portion of the stomach.

Adhesions involving the pylorus, and originating in duodenum, gall-bladder or hepatic flexure of colon may often be diagnosed by persistent abnormality of position, irregularity of outline, or sawed-off appearance, while in ptosis the fluoroscope will tell the degree of displacement, the effect of posture, of massage, of respiration upon it, and will demonstrate the fact, denied by a great many clinicians, but unquestionably true, that in many of these cases a properly-made bandage or corset, with or without a pad or bolster, will, if properly applied, hold up the stomach very definitely; in fact, the efficiency of every support should be tested by a fluoroscopic examination as, if improperly made or imperfectly applied, it may dislocate still further the ptosed organ. In our experience the support is of peculiar value in those cases of gastroptosis with congenitally or pathologically fixed duodenum, as in this group the upright position is bound to produce traction on the pylorus and difficulty of emptying. In all cases of marked ptosis, suspected dilatation, or pyloric obstruction, the stomach should be examined fluoroscopically six hours afterwards to determine the presence or absence of any bismuth residue.

By far the greatest discussion and the most work in the field has been done in connection with the X-ray diagnosis of gastric and duodenal ulcer, hyperperistalsis being the rule in both of these, associated with pyloro-spasm or spastic hour-glass stomach in the case of the former, and in the latter hypermotility, paradoxical hypermotility, with some retention or marked retention, according to the degree of duodenal obstruction, organic or due to spasm, and to the extent of dislocation of the duodenum. But we must not forget that just as in depressive states, such as myxedema, delayed motility or sluggish peristalsis may be found, so in the reverse conditions of hyperexcitability, such as various neuroses, Grave's disease, etc., we may meet with marked peristalsis or hypermotility involving both stomach and intestines—quite as marked as that in ulcer. In the second place, various organic conditions may produce gastric hypermotility, or hyperperistalsis, or both, such as achylia gastric, carcinoma of the body of the stomach, patent pylorus due to adhesions, new growth, etc., chronic appendicitis, duodenitis or duodenal adhesions, and in some cases of gall-bladder disease, and it may be most difficult, if not impossible, to differentiate the conditions from the X-ray picture alone. On the other hand, it must not be forgotten that a superficial erosion of the gastric or duodenal mucosa, absolutely undiagnosable by the surgeon by examination of the peritoneal surface, may produce exactly the same X-ray phenomena as a deep ulcer easily recognized by the surgeon on exploring the abdomen, and in the presence of other signs and symptoms of ulcer this possibility should always be kept in mind. A resumé of the work along these lines by the best-known American authorities is to be found

in *Surgery, Gynecology and Obstetrics*, March, 1914, the conclusions of which are as follows:

1. In the hands of a competent and experienced observer the Röntgen method may be of considerable service in the diagnosis of gastric and duodenal ulcer.

2. The majority of observers obtain their data by the combined use of the fluoroscopical screen and the radiograph.

3. There is as yet a sufficiently wide divergence of opinion concerning the diagnostic value of certain signs as to make the reader cautious in accepting the present views as final.

4. There is more perfect agreement on the radiographical signs due to the mechanical deformities from callous ulcers and their sequelae than on signs due to the irritation of florid ulcers or the irritable scars of ulcer.

5. The lesions accounting for a spasmodic indrawing of the greater curvature are becoming more numerous. Is there an underlying etiological factor which will explain all cases?

6. In the study of the duodenum there have developed two schools of workers; one, the followers of the European writers, which takes cognizance of all demonstrable changes in motility, and configuration, due to duodenal ulcers and their sequelae; second, those headed by Cole, who believe that all post-pyloric ulcers produce such an effect upon the duodenal walls as to make persistent changes in the configuration of the duodenal shadow. This is to be recognized by a study of a considerable series of radiographs.

7. While it is generally admitted that the radiology of the duodenum is incomplete, it would appear from the above citations that the percentage of accurate inferences regarding duodenal ulcer was greater when the method of serial radiography was used.

In the small intestine, motility, as a rule, is so great that any loop standing out clear-cut is suggestive of a distal obstruction—due to neoplasm, adhesions, ulcer, or spasm—while the dilatation or stasis of the terminal portion of the ileum is very suggestive of some cecal obstruction, and is often associated with a Lane's band. In Grave's disease and various neuroses hypermotility may be so marked that bismuth may appear in the cecum within one or two hours after its administration by mouth.

In the large intestine sluggish motility is, of course, the rule, and marked hypermotility always suggests either a local cause of irritation, such as dysentery or colitis, or a general cause, such as hyperthyroidism. By change of posture, by massage, by repeated examinations of the large inestine we try to determine the presence of adhesions, abnormal position, fixation, obstruction, etc., and yet it may be quite impossible to differentiate, for example, carcinoma, adhesions, or spasm as, notably, met with in mucous colitis, as the cause of the obstruction.

In the case of the rectum and sigmoid the fluoroscopic study of the inflow of the bismuth enema furnishes us unquestionably with

our best means of diagnosing size, shape, position and abnormalities in this portion of the digestive tract.

It will thus be seen that fluoroscopy has aided very greatly in the diagnosis of digestive disease—in the esophagus in determining various forms of obstruction; in the stomach in showing changes in size, shape, and position, in studying the motor function, in noting abnormalities in contour, in the diagnosis of ulcer, neoplasm and pyloric obtsruction, in testing the efficacy of various forms of treatment; in the intestine, in noting evidences of adhesions, of neoplasm, of abnormalities in position and form, of increased or delayed motility.

The plasticity of the method, the ability by its means to study the dynamics, as it were, of the gastro-intestinal tract, to unfold before us its physiology as well as its anatomy, the possibility of noting under our eyes the effect of the respiratory movements, of change of position, of various forms of treatment, mechanical, medicinal and otherswise—all these have made it an invaluable diagnostic aid in the field.

But that it should supplant the other means of arriving at a correct diagnosis is absolutely unwarranted—the taking of a careful history, the making of a thorough physical examination, the study of gastric contents and stool, the use of sigmoidoscope and esophogoscope, each of these furnishes information of real value in the special case without which a proper diagnosis is in most cases impossible.

To expect one method to solve a problem of great difficulty is fundamentally wrong—very few fluorscopic findings are absolutely diagnostic, individual interpretation of the picture presented varies definitely with the operator as almost if not absolutely similar pictures may be presented by different conditions.

Thus fluoroscopy should not be the only court; indeed, should not even be the court of last resort; but should simply be considered one of the many diagnostic methods to be employed in unraveling the case presented—by giving none of these methods an undue importance, by correlating the findings of all the methods employed, by giving each its proper place—then, and then only, will our diagnosis in this most difficult of fields reach the maximum degree of efficiency.

E. Merck's Annual Report. 1913. Vol. XXVI. New York. 45 Park Place.

E. Merck's Annual Report for 1913 is devoted to the recent advances in pharmaceutical chemistry and therapeutics. The first article is a most instructive discussion on lecithin. The volume is also supplemented by an article by Prof. R. Heinz on the "Standardization of Digitalis Preparations." As the edition is limited, those desirous of same can obtain by enclosing the forwarding price of fifteen cents, in stamps, no charge being made for the volume itself.

REPORT OF A CASE OF TUBERCULOSIS OF THE EYE.

By E. A. Knorr, M.D.
Surgeon at Presbyterian Eye, Ear and Throat Hospital
and
H. J. Walders, M.D.,
Pathologist to the University Hospital and Presbyterian Hospital

A. F. White, male, 32 years old, Italian, admitted to the dispensary February 16, 1914, suffering from an iritis of the right eye of two weeks' duration of a rather violent type. Vision of this eye was reduced to light perception; that of the left eye was 20/15.

The cornea of the right eye was cloudy, owing to a fine deposit upon its posterior surface. The aqueous humor was also cloudy. These conditions obscured the view of the iris somewhat, but it could be seen that the relief of the iris was effaced and that the crypts were filled with a plastic exudate which extended over the anterior surface. The exudate was more abundant in the upper part of the iris, where it formed a mass which protruded into the aqueous humor.

The pupillary margin of the iris was completely adherent to the lens. The pupil was occluded by an inflammatory exudate, which prevented an inspection of the interior of the eye. During the course of the disease the lens receded, drawing the pupillary margin of the iris with it, so that the anterior surface of the iris presented a concavity resembling the shape of a buttercup.

February 24, 1914—Subcutaneous injection of old tuberculin, 1-1000 mg. No reaction.

February 26, 1914—Injection repeated; slight general reaction; temperature 100.3; the local reaction was more pronounced; the pain of the eye increased. March 7, 1914, 1-2500 mg. injected. Shortly after this we lost sight of the patient until April 6, 1914, when he returned to the hospital, weak and emaciated, the eye presenting a perforation in the sclera in the vertical meridian, immediately above the cornea. The eye was enucleated upon this date. It was necessary to sew the margins of the perforation together to prevent the expulsion of the contents of the eye.

PATHOLOGICAL REPORT.

Gross appearance—Eye shrunken, a caseous mass in the upper meridian, just behind the limbus, which showed a perforation which extended into the ciliary processes.

On section, the anterior chamber was found to be partly filled with a fibrinous exudate. The vitreous contained a bloody fibrinous exudate. Microscopical examination: A disseminated miliary tuberculosis apparently beginning in the ciliary processes or the iris.

The lens could not be found.

The choroid showed miliary tubercles scattered through this membrane, some undergoing caseation, others in the stage of proliferation, together showing a conglomerate mass containing many giant cells. In some of the patches necrosis and beginning necrosis is evident with disappearance of pigment, except in small scattered areas.

The retina showed involvement of a proliferative type.

Tuberculosis of the eye presents itself, clinically, in three groups of cases:

1. Miliary tuberculosis.

2. Recurrent hemorrhages of the retina and vitreous followed by proliferation in the retina.

3. Toxic tuberculosis.

The case just cited is an illustration of the first group of cases, which do not differ from miliary tuberculosis found elsewhere in the body. Tuberculosis has involved every part of the eye and its appendages. The uveal tract is most frequently involved. The primary focus is usually in the uveal tract, from which it spreads by continuity and contiguity of tissue.

Primary tuberculosis of the retina has frequently been reported. In the case reported by Komoto (Kl. Monat. Bl. F. Augenh., 1911) the retina was crowded with tubercles from the ora serrata to the papilla, whilst the uveal tract, although infiltrated with cells, was free from tubercles.

This may be explained by the fact that the retina was separated from the choroid by a serous exudate.

Cases of solitary or conglobate tubercle of the papilla have been reported by Sullivan and O'Story, Komoto and Jacobs.

Second group of cases. Recurrent hemorrhages of the retina and vitreous followed by proliferation in the retina.

There is nothing unusual about the hemorrhages that occur in the vitreous and anterior chamber in cases of well-defined tuberculosis of the eye; they belong to the hemorrhages of inflammatory origin; but there occur hemorrhages which do not awaken a suspicion of their relation to tuberculosis; they are of spontaneous origin, without prodromal symptoms, and occur in persons under 30 years of age, and their etiology was obscure until Kipp pointed out their association with tuberculosis in a case reported in the Archives of Ophthalmol. in 1909.

Briefly summarized, the history of his case shows that a tubercular individual had had an inflammation of his eyes while six years of age. The scars present in the cornea make it probable that he had had an attack of phlyctenular keratitis. In his seventeenth year he had a tuberculous disease of his hip-joint, with absorption of most of the head and neck of the femur.

In his eighteenth year he had a paresis of the right external rectus muscle, which passed away in the course of a year.

In his twentieth year the left eye was struck by a piece of wood,

causing an iridodialysis at the temporal side and probably a circumscribed chorioretinitis, the scar of which was still visible.

A year later the vitreous of this eye was so full of floating opacities that the fundus could not be seen.

In his twenty-first year he had numerous hemorrhages in the retina and vitreous of the right eye, which had not sustained an injury. This was followed by a retinitis proliferans, which destroyed the sight of this eye.

In the left eye the hemorrhages of the retina and vitreous were also followed by retinitis proliferans and by many more attacks of hemorrhage in the retina and vitreous during the following two years.

In his twenty-fourth year the ophthalmo tuberculin test, one-half per cent. tuberculin, produced a well-marked reaction.

In his twenty-fifth year he is in excellent health; the right eye is blind; vision of left eye 6/8.

Kipp reported a similar case in the trans. of the Amer. Ophthal. Soc. 1895, in a boy 10 years old, who showed no sign of tuberculosis, but his father was tubercular.

Kipp states that he has seen a number of cases, in young persons in perfect health, without the least sign of tuberculosis, of hemorrhage in the retina and vitreous at intervals of one to six years.

He has also seen retinitis proliferans follow extravasations of blood in the retina and vitreous in both young and old in whom no sign of tuberculosis could be discovered.

This condition was made the subject of a paper, reported by Axenfeld and Stock before the Belgian Ophthal. Soc. 1910, in which they report several cases similar to those of Kipp. The source of the hemorrhage is from the retinal vessels, while this seems opposed to the experimental results of Stock, who, by injecting virulent tubercle bacilli in the veins of dogs, regularly, obtained a tubercular uveitis.

Group 3. Toxic Tuberculosis. Under this title are included nodular exudates in the iris, exudates in the peri-vascular lymphatic sheaths, phlyctenular disease and many other inflammations of the eye. Butler, Ophthalmoscope 1910, lays particular stress upon choroiditis at the macula in children.

The cases of this group are not caused by the presence of the tubercle bacilli in the tissues of the eye, but by the tuberculo-toxines circulating in the blood, generated in foci elsewhere in the body.

The diagnosis is made by the use of tuberculin, and with certainty only when a local reaction in the eye follows the injection of tuberculin subcutaneously.

The lesions are characterized by an evanescent course, and that they disappear usually without leaving any indication of their former existence.

Toxic tuberculosis differs from the miliary form so markedly, both in its clinical course and pathological anatomy, and many of

the cases reported not being well supported, either clinically or pathologically, their tubercular origin still remains to be verified.

That some of the authors reporting cases of toxic tuberculosis were not justified in classing them as tubercular is illustrated by the article of Butler and that of Hayashi.

Butler treated a large number of cases of eye disease with tuberculin; some of the cases gave a positive reaction; those not tested bore such a striking resemblance to those which so tested gave a positive reaction that he was compelled to regard them all as examples of obsolescent tubercle.

Hayashi's Case:

Woman, 42 years old. Two sisters died of T. B. Herself always well.

1894—Iritis of right eye.

1895—Iritis of left eye; later, iridectomized on account of elevation of tension.

1900—Second attack of iritis of right eye.

1901—Third attack of iritis of right eye.

1905—Iridectomy of right eye.

1905—Third attack of iritis of left eye. Nodes in the iris.

Patient examined by an internist. No signs of T. B.

Was given a treatment of tuberculin, 28 injections in two months. During this time temperature arose six times.

Three months later recurrence of iritis on each side. Again treated with tuberculin, seven injections. Nodes appeared in the iris and later disappeared.

1908—Admitted to hospital with spinal cord disease. Examination again failed to show signs of T. B. Died same year with pneumonia.

Post-mortem examination failed to show tuberculosis. Microscopical examination of the eye failed to show tuberculosis.

Hayashi stated that while one would have to be satisfied with a probable diagnosis, the case was no doubt tuberculosis.

The cases included in group two, which present strands of retinal proliferation, have not, as yet, received anatomical proof of their tubercular nature. The same is true of those cases of toxic tuberculosis of group three.

Book Reviews.

Collected Papers by the Staff of St. Mary's Hospital, Mayo Clinic, Rochester, Minnesota, 1913. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. Cloth, $5.50 net. 1914.

In the entire book there is hardly a paper which is not of especial interest to the surgeon. The Mayo Clinic is a practical clinic, therefore the papers issued by the staff partake of the same character, and indeed the profession is fortunate to have them collected into a single volume. Internists can also read the papers

with profit. In writing of diphtheria bacillus carriers Sanford states: Five cases have been treated recently in Rochester, Minn. (reported by Dr. H. B. Wood of the Health Department of this city), all of them giving negative cultures after a few days spraying with cultures of bacillus acidi lactici. This organism grows slowly on a solid medium, but after forty eight hours there is usually sufficient growth on agar agar slants to make a good suspension. The organisms are washed off with sterile normal salt solution and the cloudy fluid placed at once in a sterile atomizer. The living organisms are then sprayed in the pharynx and nasopharynx every four hours. We have not tried the method in enough cases to give us any statistical evidence. However, the results in these few instances seem to warrant further trial, and it is with the thought that others may find the method efficacious that we are making this report. Bacillus acidi lactici is a harmless organism, and if it will crowd out bacillus diphtheria in the throat, it would seem to be a better organism to employ in the treatment of diphtheria than staphylococcus pyogenes. Another paper of interest to the interne is "Observations on Peptic Ulcer," by Christopher Graham, who maintains the clinical history is still the greatest factor in the differentiation of lesions causing gastric disturbance. Further he states: In discussing the diagnostic features of duodenal and gastric ulcers we should consider, first, the periodicy of the attacks; second, the chronic course; third, the significant symptoms that appear during the period of attack, and fourth, the more or less ready control of symptoms, e. g., pain. He states dogmatically: If attacks of indigestion occur which are not quite clear cut; if during the attack there is some lack of regularity of symptoms; if the pain be somewhat continuous; if remissions, even, are not marked; if, together with the gastric symptoms of distress, gas, bloating, sour regurgitations, or vomiting, continuing for a few days to longer periods; and if each day the symptoms quite nearly repeat those of the day before; if some relation to food be observed; if the symptoms come on one-half to one hour or more after meals; if alkali or irrigation gives relief—if these conditions prevail we may safely exclude from the diagnosis everything but peptic ulcer. The Roentgen ray helps in many perplexing cases and promises even greater aid in the near future.

However, the greatest benefit to be derived from a diagnosis does not come from exact localization of the ulcer, but rather from the diagnosis of a lesion, and determining the patient's needs as to treatment in the light of the available symptoms. We are all agreed with the statement, "Clinical observation goes to prove that the more advanced the obstruction at the pyloric end of the stomach, other things being equal, the better is the result following gastro-jejunostomy, and, conversely, it is equally true that those cases with slight or no obstruction are to some degree less benefited by the operation. In the latter instance this result has been explained on the theory that the pylorus remains open and a portion of the food, with its irritating, though perhaps normal

acids, continues to pass by way of the natural channel coming in contact with the ulcer as before, thus giving a lessened opportunity for the ulcer to heal. This condition of free passage of gastric content by the natural route has been repeatedly verified by post-operative screen and Roentgen plate study, yet many patients whose stomachs are thus functionating are, nevertheless, without symptoms. Such is an example of the articles contained in the present volume. It is needless to quote from others, as the content material is every whit as instructive. We heartily commend the volume to our readers.

State Board Questions and Answers. By R. Max Goepp, M.D., Professor of Clinical Medicine at the Philadelphia Polyclinic; Assistant Visiting Physician to the Philadelphia General Hospital; Associate in Clinical Medicine, Jefferson Medical College. Third Edition, Thoroughly Revised. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. 1914. Cloth, $4 net.

Owing to the number of new subjects which are constantly creeping into medicine, Dr. Goepp has found it necessary to revise the above-named book, in which form he presents the third edition. As heretofore it will be found of immense value in hurriedly reviewing for a State board. The range of questions selected makes the book cover practically every question that could be possibly asked. Besides, the answers convey an idea of how much space to alot to any given question. Certainly these 700-odd pages should prove as welcome to the State board applicant as its predecessors.

Chemical Pathology. Being a Brief Discussion of General Pathology from the Standpoint of the Chemical Processes Involved. By H. Gideon Wells, Ph.D., M.D., Professor of Pathology in the University of Chicago and in Rush Medical College, Chicago; Director of The Otho S. A. Sprague Memorial Institute. Second Edition. Thoroughly Revised. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. Cloth, $3.25.

The subject of biological chemistry is daily attracting more attention, especially the part it plays in pathological processes, as the pathologist thoroughly realizes morphological pathology is near the exhaustion point. Therefore, if additional knowledge is to be thrown upon pathological processes, investigators must work along other lines than the morphological. During the past few years an immense amount of material has been added to the literature concerning biological chemistry, both physiological and pathological, but until Wells made his first book no attempt had been made to bring it together in correlated form. This edition was found to meet the needs of so many interested in this aspect of

pathology that the author, owing to the many additions to our knowledge in this line, has found it necessary to practically rewrite his book in order to bring it into accord with the latest thought. Going thoroughly into the chemistry of the cell, of enzymes, of bacteria and their products, of animal parasites, of phytotoxins and zootoxins, of immunity reactions, of means of defense against non-protein bodies, of inflammation, of disturbances of circulation and diseases of the blood, of edema, of diabetes, of uric acid metabolism and gout, of the chemical pathology of the ductless glands, etc., etc., should and will render it a book sought after by all classes interested in medical advance. It is a book written along novel lines and bound to attract attention.

International Clinics. A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles. By Leading Members of the Profession Throughout the World. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A. Volume II. Twenty-fourth Series, 1914. Philadelphia and London: J. B. Lippincott Company. Cloth, $2.

Amongst the mass of interesting articles there are at least one which should appeal to every specialist. The beauty of the series, however, lies in the simplicity with which each article is written, making it available to the general practitioner as well as the specialist. This particular number opens with an article on Health Before Birth: Antenatal Hygiene and Eugenics, by J. W. Ballantyne, M.D., F.R.C.P.E., physician to the Edinburgh Royal Maternity Hospital, formerly lecturer on antenatal pathology and teratology in the University of Edinburgh and in the Polyclinic, London, and closes with one on the Teaching of Sex Hygiene, by Maria M. Vinton, A.M., M.D., medical school inspector, New York city. Interspersed between these are any number of good vigorous articles on the various specialties.

The Clinics of John B. Murphy, M.D., at Mercy Hospital, Chicago, June, 1914. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. Bimonthly. Paper, $8 per year. Volume 3 Number 3.

Still they come, and just as interesting as when they first made their appearance. It is inconceivable how any up-to-the-minute, active, wide-awake surgeon can do without them. This number is just as full of interesting material as any of its predecessors, giving a complete and accurate résumé of the recent work done at the clinic of that renowned surgeon, John B. Murphy. In this number one is regaled with the reciting of the histories, course, outcome and operations on such varied conditions as ruptured tendons, severed nerves, bony anykyloses, fractures, ulcers of the stomach, sarcoma of the ovary and ankylosis of the jaw. As in other numbers, so here one will find about 200 pages full of practical suggestions, hints that can be put to every-day use.

MARYLAND MEDICAL JOURNAL

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BALTIMORE, OCTOBER, 1914

SCHOOL HYGIENE.

IN many instances the best way to reach the adults is through the school children. If the child can be taught an important principle in hygiene it is almost axiomatic that the parents will be inveigled into sufficient curiosity to reach them. Peculiarly, in the beginning, medical inspection of school children had as its prime object not the protection of the sick child, but his healthy schoolmates from contagious diseases.

Slowly it became generally realized that there was a much broader usefulness to which supervision of school children could be applied, namely, the correction of any physical or mental stigmata with which they might be afflicted. Though the first medical school inspection was inaugurated in France in 1833, it was not until 1888, in Strassburg, that Dr. Jessen opened the first school children clinic for children suffering with mental or physical defects. Today the idea has even been carried farther and the environment of the child is thoroughly studied so that the proper remedies can be applied. According to E. F. Brown, Bulletin of the American Academy of Medicine, health is a necessary complement of a communal economy. Should one single member of society be rendered unproductive through the complete destruction or partial reduction of his physical or mental vitality, society as a whole suffers in at least three different ways.

1. That which has been a useful productive element in our social order has been rendered economically sterile.

2. Society must therefore assume the obligation of caring for this non-producing unit through its producing units by taking a

share of the proceeds of the wealth-producing parts and contributing it to its economically pauperized member.

3. Usually the contribution by the producing members of society to the support of the incapacitated member makes necessary certain social sacrifices on the part of those who are usually unable to bear the burden without serious detriment.

The root of these three concrete social evolutions is traceable directly to ill health. Therefore, that which contributes to the physical well-being of the race is no small factor in the promotion of social content. In no wise can this social contentment be fostered better than by looking after the health of the child. In order to meet the stress of life the youth about to launch forth for himself must, to produce the best results, have a healthy body and mind. If not, he starts life handicapped and is apt to be distanced by those more fortunate. It is therefore a good investment to the community to be most careful about the hygiene of school children. It is a debt that the community owes to the children. It is an insurance against later ineffectiveness and social discontentment, Brown states. If adenoids cause respiratory disability which render the child less amenable to instruction, and accordingly result in the loss to the child of the opportunity to learn a skilled trade or profession, the child will suffer from the intermittency of unskilled employment and its concommitant low wage. Under these circumstances adenoids are enemies of the social order, which must be destroyed. Only in so far as we have the foresight and courage to look beyond the conditions which are causing our social discontent will we make possible the larger share of happiness which is certainly the due of an increasing number of our fellow-beings. One avenue, and a most promising avenue by which this happy result may be brought about, is school hygiene. Undoubtedly the past with its limited experience has proven that the time, energy and moneys thus expended have been well spent. The broadening of the supervision into channels not at present thought of will mean untold of returns to communal happiness through the production of citizens contented in mind and sound in body.

Medical Items.

In addition to the general fund of $1,500,000 recently given to the Johns Hopkins University Medical School, Baltimore, the General Educational Board is said to have appropriated a fund of $50,000 for the development of the Hunterian laboratories of the school.

Sir William Osler, formerly of Hopkins Hospital, now regius professor of medicine at Oxford University, England, has been made an honorary colonel in the British Army.

The twenty-fifth anniversary of the opening of Johns Hopkins Hospital, the twenty-first anniversary of the opening of the medical school, the second reunion of the alumni of the medical school and the first general reunion of the alumni of the training school for nurses will be made the occasion of an elaborate celebration at the hospital, which will open on October 5 and continue throughout the week.

Dr. H. Flournoy, resident psychiatrist at the Phipps Psychiatric Clinic of Johns Hopkins Hospital, left Baltimore August 14 to return to Switzerland in answer to his country's call for reservists.

The call came through the Swiss Ambassador at Washington. Dr. Flournoy will go home in a roundabout way, because of the shipping conditions brought on by the war. He will sail on an Italian steamer from New York, will go down the Atlantic, with possibly a stop at the West Indies, to the Mediterranean, thence to Marseille, France. From Marseille he will go to the mobilization point by rail.

Dr. Flournoy is a member of the medical reserves of the Swiss Army. He has served in that army.

So rapidly has the building of the new South Baltimore Eye, Ear and Throat Hospital progressed that Dr. Harry E. Peterman, the superintendent, expects to open it October 1.

Since their return from Europe in July, Dr. and Mrs. Henry Barton Jacobs have been occupying Whiteholme, their villa at Newport, where they will spend the remainder of the season, returning to Baltimore in the fall.

Much interest is taken in Baltimore in the advancement of Dr. Louise Pearce, formerly of Baltimore, to be an assistant to Dr. Simon Flexner of the Rockefeller Institute for Medical Research in New York.

She went to the institute last August from Johns Hopkins University, and is the first woman who has been made an assistant to Dr. Flexner.

Before her appointment she was the only woman on the staff of Johns Hopkins Hospital, and shortly before going to New York she was appointed to the psychiatry staff of the Phipps Clinic. Here again she was the first woman who ever received the honor.

Dr. and Mrs. C. Urban Smith have been spending some time at Eaglesmere. They made the trip in an automobile.

The demands of war will take away from the Johns Hopkins Hospital one of the members of its staff. He is Dr. Felix Landois, who is associated in surgery with Dr. William S. Halsted. Dr. Halsted has been spending his vacation in Europe, but he is now thought to be on his way to this country aboard the Mauretania.

Dr. Landois, who is a captain in the medical corps of the German Army, will go first to Breslau, and thence will proceed to the point where his regiment is stationed. He will sail as soon as he can obtain accommodations. Dr. Landois came to Johns Hopkins last January, intending to spend a year. The war means that his stay has been practically cut in half.

Dr. Landois was on his vacation in the West when Germany entered upon the war. He was communicated with and immediately returned to Hopkins to make preparations for his departure for Europe.

Dr. N. A. Christensen has been appointed accident physician at Mercy Hospital. He succeeds Dr. Thomas F. Bess, who resigned and went to Hinton, W. Va., to practice his profession. Dr. Christensen graduated last year from the College of Physicians and Surgeons.

Two women who have many friends in Baltimore and who are now in London are Drs. Mildred Clark of Brookline, Mass., and Mary A. Hodge of San Diego, Cal. They graduated from Johns Hopkins Medical School last June, and went abroad almost immediately.

The Johns Hopkins Hospital has lost one of its staff and the Baltimore Athletic Club is minus a star athlete as the result of the sudden departure on Thursday of Dr. Grant Ferguson. The physician has gone back to his native land, Scotland, to take part in the European war. He left for New York on August 6 to sail for Europe.

Dr. Ferguson was graduated in June from the medical department of the Johns Hopkins University. At the Baltimore Athletic Club he

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was considered among the best of the wrestlers. He is said to be the light heavyweight champion wrestler in the South Atlantic Amateur Association.

Dr. Joseph Spark, University of Maryland Medical School, 1913, has left the Municipal Hospital, and will probably locate in Martinsburg, W. Va.

Dr. T. A. Ashby and Dr. David Streett of the University of Maryland faculty attended the fifth annual reunion of the New York Medical Alumni of the University of Maryland, held at Syracuse, N. Y. Both professors discussed the merger of the University of Maryland and the Baltimore Medical School at the banquet. About 20 Central New York physicians attended the reunion.

Dr. and Mrs. Robert T. Wilson of 820 Park avenue has veen stopping at Baltimore Inn, Cape May, N. J.

Dr. George Hoyt Whipple has resigned as associate professor of Johns Hopkins University and has been appointed director of the Hooper Foundation for Medical Research by the board of regents of the University of California. Dr. Whipple is widely known in his profession. He is a graduate of Yale University and the Johns Hopkins Medical School. He served for several years in the Ancon Hospital in the Panama Canal Zone and is a member of many medical and research societies. Dr. Milton C. Winternitz has been appointed to succeed Dr. Whipple.

Surgeon Leslie L. Lumsden, Public Health Service, and Dr. John S. Fulton, secretary of the State Board of Health, are to make a thorough inspection of health conditions in Dorchester county. Dr. William H. Welch, president of the State Board, is now in Europe. On his return the board will take up the matter of appointments for six additional health officers. At the last session of the Legislature the State was divided into 10 sections and provisions made for a health officer in each district. So far, but four officers have been appointed.

MARRIAGES.

Charles F. W. Bove, M.D., Baltimore Medical College, 1913, of Cumberland, Md., to Miss Cecelia H. Flaig, formerly of Catskill, N. Y., at Catskill, August 22, 1914. Dr. Bove was formerly connected with St. Joseph's Hospital, Baltimore.

J. G. Fowble Smith, M.D., University of Maryland Medical School, 1906, of Sykesville, Md., to Miss Sara Frances Moore of Silver Springs, Md., at Elkton, August 15, 1914. Dr. Smith is a member of the Springfield State Hospital staff.

Alfred W. Yocum, M.D., Baltimore Medical College, 1912, of Sparrows Point, Md., to Miss Daisey C. Disney of Baltimore, Md., at Baltimore, in September. Dr. and Mrs. Yocum will make their home in China, where the doctor has been assigned to the Oxner Memorial Hospital in Pingtu, Shantung, as a medical missionary.

Oswald S. Lowsley, M.D., Johns Hopkins Medical School, 1912, of New York city, to Miss Katherine V. Staples of Troy, N. Y., at Round Lake, N. Y., August 20, 1914. Dr. Lowsley is associated with the Bellevue and Allied Hospital of New York city. He was formerly director of athletics at the Baltimore Athletic Club and Maryland Swimming Club. Miss Staples is a graduate of the Johns Hopkins Nurses' Training School.

Harry W. Rosenthal, M.D., College of Physicians and Surgeons, to Miss Ruth A. Mashbach, both of Baltimore, Md., at Baltimore, August 8, 1914. After October 1 Dr. and Mrs. Rosenthal will be at home at 3524 Fairview avenue.

DEATHS.

Lafayette Coffman, M.D., Maryland Medical College, 1905, of Peggs, Okla., died in Talequah, Okla., August 3, 1914, aged 45 years.

James B. Garvey, M.D., College of Physicians and Sugeons, '84, a Fellow of the American Medical Association, died at his home in Dunmore, Pa., August 23, 1914, from acute gastritis, aged 71 years.

Leonard H. Spalding, M.D., University of Maryland, '69, for thirty-three years a practitioner of Peoria, Ill., died in Rochester, Minn., August 22, 1914, from heart disease, aged 69 years.

Thomas Joseph Murphy, M.D., College of Physicians and Surgeons, '99, a member of the Maine Medical Association, died at his home in Bangor, Maine, August 14, 1914, aged 41 years.

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Abstracts.

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Dr. George A. Leland, Boston.

Paper read at the Thirty-fifth Annual Congress of American Laryngological Association, held May 5, 6 and 7, 1913, in Washington, D. C.

Our founders builded wiser than they knew when they chose the throat as a field for their specialty; for here, as shown by modern bacteriology and clinical observation, is the port of entry of many of the diseases to which poor human flesh is heir. It is well established that through the nose and throat may enter the micro-organisms which cause tuberculosis, nephritis, endocarditis, sepsis, cerebrospinal meningitis, acne, erythema nodosum, erysipelas, etc., and by extension up through the Eustachian tube, aural diseases of all sorts leading to deafness, pyema, meningitis, intracranial abscess, etc. It is the province of preventive medicine to obviate all this and to put the upper air passages into the best possible shape. If the nose and throat can be put in proper shape and continuously used, the occupation of the aurist will be gone except for the effects of traumatism, and perhaps for the infections.

SYMPOSIUM ON PHLEGMONS OF THE UPPER RESPIRATORY TRACT—REPORT OF A CASE.

Dr. F. E. Hopkins, Springfield.

Paper read at the Thirty-fifth Annual Congress of American Laryngological Association, held May 5, 6 and 7, 1913, in Washington, D. C.

This case illustrates the possibility of erosion of a large blood vessel. The patient was a male, 26 years of age, of poor resistance because of leading an irregular life and having had a recent acute illness. He had suffered from measles, and while convalescing took cold. There was marked swelling on the left side, with severe pain, but the patient was not prostrated, and at no time did his temperature go above 101° F., or his pulse above 80 or 90. Deep incisions were made, but these yielded no pus, and there was no evidence of pointing. Two days later a hemorrhage occurred, which was controlled by pressure. On the following day a terrific hemorrhage occurred, and quickly proved fatal. Such an examination as could be made immediately following death showed rupture through the posterior pillar, the flood from the eroded carotid finding exit there. Such a mass of cellular infiltration should be explored with a blunt instrument, even the finger, following unfruitful incision. The wonder is not that phlegmons threatening life occasionally develop, but rather, considering the frequency with which infections of this region occur, that they are so rare that an active professional life may pass and not a single one come under observation. Microscopic findings are of little value in determining the treatment of these cases. Early and effective drainage is the best assurance of a favorable prognosis. Suffocation from flooding of the larynx by the sudden rupture of an abscess has been reported, and tracheotomy has been required because of closure of the pharynx by infiltration and edema, but the complication I wish to emphasize is that of erosion of blood vessels by the necrotic process.

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FOREIGN BODIES IN THE ESOPHAGUS, WITH REPORT OF TWO CASES.

Dr. Cornelius G. Coakley, New York.

Paper read at the Thirty-fifth Annual Congress of American Laryngological Association, held May 5, 6 and 7, 1913, in Washington, D. C.

The first patient, a boy of 16 years of age, thought he had swallowed a piece of plate in his soup. He had a temperature of 105°, rapid pulse and pneumonic area in the right lung when first seen. Examination of the pharynx showed edema extending from the vault of the nasopharynx as far down as one could see with the laryngeal mirror, or feel with the fingers. It much resembled a retropharyngeal abscess. The X-ray showed a triangular-shaped foreign body. It was jagged, and evidently had cut into the mucous membrane so as rapidly to infect the pharyngeal mucosa, and the secretion from the infected pharynx passing into the larynx, setting up a septic pneumonia within 24 hours. The boy died 14 hours after the operation from acute septic pneumonia. This case shows the necessity for the prompt operative relief for removal of sharp foreign bodies. The same day I saw a boy three years of age who had swallowed a coin. The X-ray showed the coin at the level of the sixth cervical vertebra. The child had no symptoms. The coin was removed by operation, and the child suffered no subsequent discomfort. In this instance the coin had been in position for five days before it was removed.

INFLAMMATION OF THE LATERAL COLUMNS OF THE PHARYNX LEADING TO ABSCESS FORMATION, WITH REPORT OF CASES.

Dr. Henry L. Swain, New Haven.

Paper read at the Thirty-fifth Annual Congress of American Laryngological Association, held May 5, 6 and 7, 1913, in Washington, D. C.

Any isolated mass of lymphoid tissue can in a general way be expected to act when inflamed exactly after the fashion of the faucial tonsil, and can have, like the latter, simple, acute, follicular, rheumatic, diphtheritic and phlegmonous inflammations. The adenoid or pharyngeal tonsil may have acute as well as chronic inflammation. The same is true of the lingual tonsil. If we continue to remove root and branch from young children all of their adenoids and faucial tonsils, there will be abundant need to devote more and more attention to these masses of lymphoid tissue, as well as to the lingual tonsil. In years gone by, when adenoids were removed from children and the faucial tonsils were left untouched, the latter subsequently enlarged into a perfectly healthy growth, as though needed by the system. If the faucials are thus ruthlessly removed, there will be enlargement of the lingual tonsil or lateral columns of the pharynx, as there has been of the faucials following the older simple adenoid operation. If this is logically true, we will find not only acute inflammations of these structures, but also phlegmons. We have assumed more or less arbitrarily that as the lateral column of the pharynx is no mean mass of lymphoid tissue, and as it has been known to have all other kinds of inflammation to which lymphoid tissue is heir, we have a logical right to expect that there may also be the phlegmonous type, and I propose to submit facts concerning certain cases

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confirmatory of this statement. I recently had six cases of edema of the larynx, in two of which there was no quinsy at all. There was inflammation of the lateral column of the cord in both these instances, and there was in one a marked general, what may be called rheumatic, infection, where various joints of the body were affected, with no persistence of the symptoms in any one place for any length of time. In these various cases of edema one has to look to some other cause than pressure.

PHLEGMONS OF THE UPPER RESPIRATORY TRACT.

Dr. John O. Roe, Rochester.

Paper read at the Thirty-fifth Annual Congress of American Laryngological Association, held May 5, 6 and 7, 1913, in Washington, D. C.

The phlegmon is simply another name for inflammation, although clinically it is regarded as an extraordinarily intense inflammation, and looked upon as being of more or less malignant character. We may have an inflammation of this character in any part of the body, the intensity of which may depend upon the virulence of the infection and the resistance or lack of resistance of the patient, or of the tissues, to such infection. Owing to the difficult breathing or choking which such inflammation causes in the upper air passages, it has received the name of angina. Inflammations of a severe grade, termed phlegmons, may involve any portion of the upper respiratory tract. We almost invariably find a phlegmon attacking one whose general condition has become weakened. The treatment of these infections requires no special law unto itself, and must be dealt with according to the location and associated complications.

PRIMARY CARCINOMA OF THE EPIGLOTTIS, WITH REPORT OF A CASE.

Dr. Emil Mayer, New York.

Paper read at the Thirty-fifth Annual Congress of American Laryngological Association, held May 5, 6 and 7, 1913, in Washington, D. C.

Primary cancer of the epiglottis is a rare disease, and up to the present time the treatment has consisted of surgical intervention or the use of radium and the X-ray. I have seen two cases of cancer of the epiglottis. The first case was diagnosed as probable malignant disease of the epiglottis, and the subsequent history was that of primary epithelioma of the larynx with subsequent metastatis, laryngectomy, and death. The second case was that of a man, 64 years of age, who consulted me for some slight difficulty in swallowing, especially the swallowing of cold liquids. His general condition was good.. Examination showed some edema of the uvula, and numerous small white spits on the tongue and inner surface of the cheek. The condition was diagnosed as leukoplakia buccalis. He gave no history of lues. After treatment he improved somewhat, but this did not last, and some six or seven months later there was discomfort in swallowing, a nasopharyngeal catarrh, and the white patches still present. There was no other evidences of a diseased condition in the throat. About three weeks later a new condition presented itself on the laryngeal surface of the epiglottis. There was a deep ulceration surrounded by a thickened mass. The pathologist pronounced this cylindrical celled carcinoma. Here I had a case of carcinoma

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of the epiglottis in its earliest stages. The epiglottis was removed, after the patient had been anesthetized and the suspension laryngoscope placed in position. There was little bleeding at the time of the operation, but 26 hours after the patient began to expectorate large quantities of blood. This bleeding was checked by the application of ice internally and by sprays of peroxid of hydrogen. He left the hospital in 10 days. This was the first operation of its kind ever performed under the ingenious suspension laryngoscope of Killian.

NITROUS OXID GAS, ESSENCE OF ORANGE, ETHER AND SEQUESTRATION IN GENERAL ANESTHESIA FOR OPERATION IN THE UPRIGHT POSITION.

Dr. Thomas R. French, Brooklyn.

Paper read at the Thirty-fifth Annual Congress of American Laryngological Association, held May 5, 6 and 7, 1913, in Washington, D. C.

We are now able to state that as a result of the movement of the new operating table, and also as a result of the tests made in our clinic at the Long Island Hospital, that operative work in the upright position can be done with still less loss of blood, with the need of still less of the anesthetic, and with less disagreeable conditions during recovery from the anesthetic. Sudden changes in posture or sudden disturbances of the body while patient is under a general anesthetic, predisposes to shock, the effects of which are manifested both during the operation and during the recovery from anesthesia. After a careful study of this phenomenon, I became impressed with the value of elevation of the body from the recumbent position to the upright position without jarring, and this led to the construction of the chair table. By the aid of a new attachment all the movements of the body are now made with as great freedom from jarring and disturbance of balance, with infants and very small children, as had hitherto been possible only with adults or larger children. The resulting improvement in conditions leaves no doubt of the accuracy of the observation. One of the most important and valuable recent additions to methods of anesthesia is the ability to omit or bridge the second stage, or stage of excitement, and we have been impressed with the desirability of attaining parcosis without struggle. This can be accomplished with nitrous oxid gas, but with greater ease and certainty with the essence of orange. The discoverer of the remarkable effects of the essence of orange as a preliminary to ether, Dr. Gwathmey of New York, has demonstrated the possibilities, and has proven to our satisfaction that it greatly assists in the reduction of shock by bridging the stage of excitement. Anesthesia conducted in this way up to the time of raising the body to the upright position is a contributory factor in reducing hemorrhage, and also in reducing the quantity of anesthetic and in shortening and modifying the anesthetic after-effects. Irrespective of all other conditions, there is a well-defined relationship between the degree of skill in which a patient is anesthetized in the upright position and the amount of hemorrhage is reduced if the anesthetic is smoothly given. A preliminary use of nitrous oxid gas or the essence of orange and the drop method of anesthol, followed by the drop method ether with the open inhaler, and

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later with the Allis inhaler, will insure a prolongation of the anesthesia after the body has reached the upright position, a reduction of hemorrhage, and a reduction in disagreeable sequelæ. Sequestration of the limbs produces a congestive hyperemia, and is produced by means of inflated blood pressure cuffs about the thighs and arms; this reduces the amount of blood in the head. This, in association with the upright position which has been carried out in 58 cases during the past season, reduces still further the amount of anesthetic required, and still further the loss of blood. There need be no apprehension of subsequent bleeding.

TRAINING OF THE SPECIALIST.

Dr. Thomas J. Harris. New York.

Paper read at the Thirty-fifth Annual Congress of American Laryngological Association, held May 5, 6 and 7, 1913, in Washington, D. C.

A concentrated advance movement to properly standardize our specialty is essential. The time is now ripe. As an outline for a more definite working basis, some such plan of instruction for special work may consist in the following divisions: First, thorough preparation in the undergraduate medical school; second, a general preliminary training through several years of practice or hospital internship; third, at least six months of special instruction covering not only the clinical side, but the anatomic, pathologic, surgical, etc., as well; fourth, 18 months of internship in a special hospital or in the ear, nose and throat department of a general hospital; fifth, at the conclusion an examination by a university which should confer upon the successful candidate a postgraduate degree. The committee appointed to investigate and report on this subject is strongly of the opinion that the postgraduate instruction should be given in some established university, and, further, that to make this departure a success, legislation will be necessary. The committee is of the opinion that any success in this movement must be the result of concerted action on the part of the several societies representing America and Canada.

HISTORY OF A BRONCHOLITH, BRONCHIAL CALCULUS OR LUNG STONE.

Dr. Walter F. Chappell, New York.

Paper read at the Thirty-fifth Annual Congress of American Laryngological Association, held May 5, 6 and 7, 1913, in Washington, D. C.

This case is cited to show that all causes of asthma are not centered in the nose, nor all throat coughs in the larynx. The patient was a woman, 52 years of age, who was attacked by severe weezing, the spasmodic cough lasting an hour at a time, and by intense tickling in the throat. The tickling was below the larynx, and the wheezing in the upper part of the chest, in front and behind. The patient soon raised a small calcareous mass, but the asthma continued. Another coughing spell resulted in the expulsion of a large calcareous mass. Immediately all wheezing stopped, and the breathing became absolutely free. Later another calcareous mass was coughed up. Chemically these masses consisted of phosphate of lime. The patient gave no history that would give a clue to the cause for the existence of this condition.

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AN announcement that will undoubtedly occasion widespread interest among physicians is appearing in current medical journals over the signature of Parke, Davis & Co. We refer to the announcement of Typhoid Phylacogen. The new product is prepared from pure cultures of the bacillus typhosus of Eberth and Mixed Infection Phylacogen. As the name signifies, this latest Phylacogen is indicated in the treatment of typhoid fever or any pathological condition due to infection with the bacillus typhosus. Before being formally offered to the medical profession Typhoid Phylacogen was subjected to rigid clinical tests extending over two years. The most significant fact developed by these investigations appears to have been the prompt amelioration of symptoms and rapidity of recovery in successful cases. Indeed, it is evident that, when properly treated, recovery not uncommonly takes place in approximately half the time required under conventional methods.

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before the Medical Society of Montreal and later published in *L'Union Médicale du Canada*. Dr Benoit refers at some length to a number of typhoid cases that were treated at the Notre Dame Hospital, concluding his paper with the significant observation that "the treatment of typhoid fever with Phylacogen gives real results." Physicians are advised to send for a copy of this "Typhoid Phylacogen" pamphlet, addressing their requests to Parke, Davis & Co. at their home offices in Detroit, Mich.

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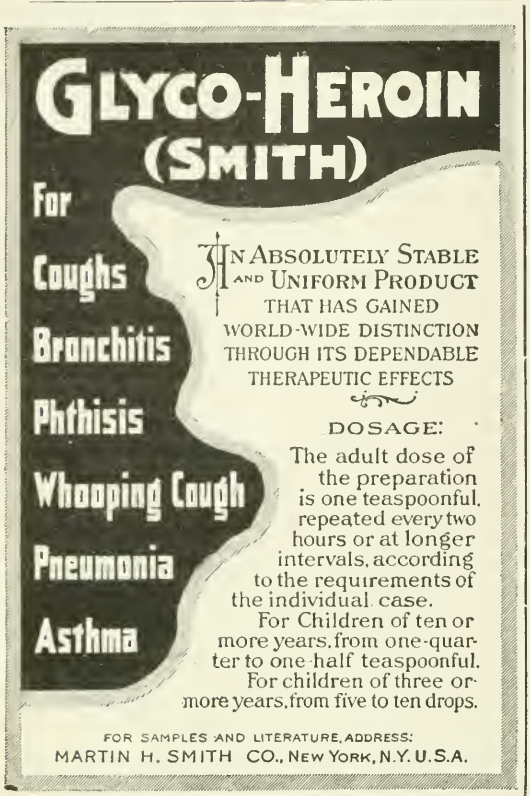
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